GIBBONS (H)

A PROTEST

AGAINST

MEDDLESOME MIDWIFERY

By H. Gibbons, Sr., M. D.

[Read before the San Francisco County Medical Society.]

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A PROTEST AGAINST MEDDLESOME MIDWIFERY.

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A student of the late Dr. Ch. B. Meiggs, Professor of Obstetrics in Jefferson Medical College, related to me the following incident: The Professor entered the lecture room one day at the usual hour, and placing his manuscript on the desk, pronounced this text in a very deliberate and serious manner: "Gentlemen, meddlesome midwifery is bad." Then turning over the leaves of his manuscript a few moments, he repeated: "Meddlesome midwifery, I say, is bad." Then walking backwards and forwards several times, he returned to the desk and repeated: "I say, gentlemen! meddlesome midwifery is bad." After a long pause, he resumed: "Gentlemen! I do not know that I could occupy the hour allotted to my lecture in any better way than by repeating, and iterating, and reiterating: "Meddlesome midwifery is bad."

Professor Meiggs was not averse to the use of the forceps. On the contrary, he had done as much as any man in America, perhaps more, to promote their use. It was only after long experience that he uttered the caution above related. We seldom have such admonitions at the present day. The tendency is in the opposite direction, to encourage interference with the natural process of labor, to hasten the result by mechanical means, and to denounce, often with harshness, the practice of those who fear or hesitate to make frequent application of the forceps.

The medical journals abound with essays and discussions on the use of the forceps. Every medical society takes up the question at intervals and reports the discussion. Mostly, the subject is handled as if there were but one factor to be regarded, viz., the instrument. Men seem to forget that the forceps alone can do neither good nor harm—that the hands and the brain are

essential factors. It is not the forceps that do good or harm, but the *man* with the forceps. If the brain has been duly cultivated and the hands duly educated, then the forceps are a blessing. But in opposite circumstances they are dangerous.

That the lives of many mothers and infants are saved by the forceps it were folly to dispute. That a considerable number of lives are lost which might be saved by instrumental interference, is equally plain. But the recorded experience of the older obstetricians who lived at a time when labors were left almost altogether to nature, proves that instrumental interference is absolutely necessary in a very small proportion of cases—at least to save the mother's life. I need not remind my hearers of the statistics on record referring to this subject, showing what a very small percentage of cases in charge of distinguished accoucheurs, failed of a successful result in the hand of nature, unaided by instruments.

We are naturally prone to refer to our own experience in all such matters. It is not only right that we should do so, but it is our duty. The memory and the note book of every observant and conscientious medical man present a record which should never be thrust aside to make way for the assertions and opinions of others. Let me refer briefly to my own experience, now covering over fifty years of constant practice, with the ordinary allotment of puerperal cases. When I began, and for many years afterward, the forceps were not much employed by any one, and I very seldom used them. Later, I have employed them more frequently, but still not often. Had I my professional life again before me with my present experience, I am free to confess that I should resort to the forceps, say from five to ten times, where I have done so but once. With this sparing resort to the instrument, I am certain that I never lost a patient on account of not using them. There is no observation of my life that I could assert with greater confidence.

This refers to the mother. As to the child, I cannot say so much. On the contrary, I am quite certain that a resort to the forceps would have saved the lives of several children in cases of which I have a special record. But the proportion of still births in my charge has been small, and scarcely any have resulted from prolonged or lingering labor.

Another fact I desire to state—I have had only one case of

vaginal fistula in the whole course of my practice. This was in a primipara, at full term, but with a fetus which died some days before the commencement of labor. The dead fetus caused inertia of the uterus and prolonged labor, from which resulted the disaster. Here, I have no doubt the unfortunate accident would have been prevented by instrumental interference. I have this excuse for the omission. The case occurred in the country and at a time when I was almost entirely disabled by a carbuncle on the neck, and under circumstances which rendered it impossible to procure professional aid.

With this solitary exception, I entertain the belief that I never attended a patient in childbed who suffered any other unpleasant result in consequence of the non-employment of the forceps than an unnecessary prolongation of labor.

If the zealous champions of the forceps were to address themselves to experts only, they might do no harm. But it is impossible for young and inexperienced practitioners to follow their counsel with safety. Besides, a very large proportion of physicians practicing in rural districts where the population is sparse, are not possessed of the dexterity and skill necessary to render the instrument safe in their hands. It cannot be otherwise, for the opportunities of acquiring dexterity and skill are wanting. Nor is it always possible to call in the aid of expert counsel. But something must be done. One cannot afford to lag behind the times. . The books and the teachers command action. It is a forceps case, beyond doubt. Shall the patient be allowed to die because the doctor lacks confidence in his own skill? So the forceps are applied—or the attempt is made. Perhaps the experiment will succeed. At all events, let the doctor persevere, and if he fail with one case, let him try another, and so on. In the course of time he will acquire the "know how." But in all probability he will have injured or killed a larger number of women and infants in learning the art, than he will save or benefit by the forceps in all the future.

To say that if every forceps in the United States were destroyed, and the use of the instrument entirely suspended for a year, the number of puerperal casualties would not be increased in consequence, would be regarded as a very bold statement. Especially would our skilled gynecologists raise their hands in horror. It would be equivalent to declaring that the harm done

by the instrument in incompetent hands or in cases not requiring it, is enough to balance the good arising from its proper use. Were it necessary for me to pronounce on one side or the other of this proposition, I should take the affirmative, notwithstanding the opposition and censure that such an opinion is likely to bring upon me from men at the head of the profession.

Perhaps I am unduly influenced by what I have witnessed of the abuse of the forceps. During my residence in California, embracing nearly thirty years, I have been very frequently called in consultation in difficult obstetric cases, in which the accoucheur in charge had employed the forceps, or could not succeed in introducing the second blade, or in locking the blades after introduction. Another class of cases in which my counsel has been often required is when some mishap has occurred after forceps delivery. In many instances no other purpose appeared to have prompted the interference than to save the time of the practitioner. My memory retains in abundance the most lively impressions of calamitous results associated with the forceps under these circumstances.

I was once summoned by a medical gentleman—not a young man, nor without some reputation as an obstetrician—to assist him in a forceps case. I found him with the instrument in hand, and waiting only for me to be present and to administer chloroform. Without asking my opinion, he proceeded hurriedly to introduce the forceps as the woman lay on her side, and when he came to the second blade, he actually lifted her with his left hand under her hip—for he was a strong man—whilst forcing the instrument to its place with the other hand. He then dragged the child forth with violence, and threw it aside to my keeping. It was still born, but breathed feebly after resort to the proper means. It died, however, in a few days, and the mother followed it, succumbing to inflammation. There can be no doubt here that both mother and child were killed by the forceps, though the inanimate steel was not responsible.

If the forceps have done all the good claimed for them since their introduction into general use, should we not have some diminution of the uterine troubles of married women? And has such a diminution taken place? These questions open an interesting field of inquiry, too extensive, however, for my present purpose.

But it is not only in the hands of incompetent and unskilled

practitioners that mischief is done with the forceps. The most skillful manipulators are often to blame. So dextrous and expert are some masters of the art in the application of the instrument, that they are induced by their very proficiency in this respect and by their self-confidence to interfere when there is no occasion, and we might say, take the business of delivery entirely out of the hands of nature. An illustration in point I find in the "Transactions of the American Gynecological Society," at a recent meeting held in Philadelphia. On that occasion a distinguished accoucheur advocated the use of the forceps in the first stage of labor, when the os uteri is "dilated only to the size of seven-eighths of an inch in diameter" and there is no progress. True, he does not employ the ordinary forceps, which are acknowledged to be too wide, but "*his*" thin, narrow-bladed instrument. His method too is peculiar, the object as stated being, not to make traction, but "simply to retain the head of the child in contact with the os uteri during and after a pain, and in some cases to aid in flexing the head, so that the occiput may become the natural dilator of the cervix." After fifteen or twenty minutes, *if* there is no advance, he "removes the forceps and re-applies them at the end of a few minutes." "In that way," it is added, "the instrument may be applied three or four times before sufficient dilatation is effected."*

It is surprising what an amount of rough usage the uterus will often bear without apparent injury. In eighteen years of this practice, Dr. Isaac E. Taylor, of New York, has "never seen any evil consequences from it." He must have employed the procedure largely also, being in charge of the obstetrical departments of Bellevue and Charity Hospitals, besides his private practice. Some physicians appear to be blessed with what is called "luck." Dr. Taylor has certainly enjoyed a larger portion of good fortune than falls to the lot of accoucheurs in general. But "fortune favors the brave."

Now suppose all the practitioners in the United States who can handle the forceps with an average amount of skill, were to undertake the introduction of the instrument, even the *thin* forceps of Dr. Taylor, in every case of retarded labor with the os uteri dilated less than one inch in diameter. And if successful in the introduction, suppose them withdrawing the two blades

* Vide American Journal of Obstetrics, October, 1879, p. 836.

and reintroducing them again and again in tardy cases. What would be the result?

The truth is that a very small proportion of medical men can, by any possibility, possess themselves of sufficient experience and skill in the use of forceps to justify their attempt to follow the example of Dr. Taylor. Only in populous centers, and there only in connection with public institutions, can such experience and skill be acquired. The acquisition must depend on special study and practice, and this is impossible to medical students during their curriculum, and possible to a very small proportion afterwards.

Specialties in medicine are rendered necessary at the present period, by the boundless field of research which medical science has opened for itself in modern times. But there are and always will be evils connected with specialties. The specialist can scarcely avoid giving undue weight to the facts and considerations which his favorite study keeps in the view of his mind. In the treatment of disease, he will be most likely to employ the means presented by his specialty, to the neglect of other means. The surgeon resorts to operative procedures when the ordinary practitioner would depend entirely on drugs. The gynecological expert, confident of his knowledge and skill, ignores the therapeutics of the every day physician. Is he perfect master of the forceps? He will scarcely employ any other agency. He will take the business of delivery out of the hands of nature and substitute his own familiar methods. Should any mishap follow, he will find some other cause for it than his favorite procedure.

I hold that all unnecessary handling, either with or without instruments, should be avoided in the management of labor. I maintain further, that instrumental interference is unnecessary in the first stage of labor, when the os is dilated less than one inch—possibly with some rare exceptions; that it is not only unnecessary but liable to do mischief; and that it should never be attempted by any other than an expert operator.

But what is to be done in the case referred to, when there is suffering without progress? Must the woman be allowed to endure the pangs of labor fruitlessly, until perhaps she shall become exhausted? By no means. Give her a narcotic—one third to one half grain of morphia, or two grains of opium—a decided dose. The quantity should be regulated by the effect, not by the weight; for women in labor bear large doses of

opiates, the pain neutralizing the narcotic action. Your patient will become quiet and sleepy in fifteen or twenty minutes and labor will apparently cease. If you leave her under these circumstances and go home to your bed, the chances are that just as you get asleep the door bell will ring, and when you return to your patient you will hear the infant crying.

In the early part of my practice, nearly fifty years ago, I was called to a patient in the country, in the first stage of labor. The os was partially dilated, but the advance was very slow. Desiring to visit another patient a mile or so distant, I gave the parturient woman a dose of opium to keep her quiet until my return. I hurried back, having been absent about an hour, and to my surprise found that the woman had given birth to her child in half an hour after my leaving her. A number of similar experiments, made with the design of arresting labor, taught me a lesson on which I have acted through the whole course of my practice since that time. Every one knows the effect of opiates in arresting premature or threatened labor when not too far advanced. If the term of gestation has fully expired and pains come on, an opiate administered early, will mostly arrest and suspend labor for a brief period. But if the labor have decidedly advanced and dilated the os so that it *must* proceed to completion, opiates have no such effect. They relieve pain and at the same time relax the circular fibers of the uterus and its neck, whilst the longitudinal fibers continue to act, but painlessly, in the expulsion of the fetus.

It may be objected that bad effects in some directions are liable to follow the use of opiates. But such has not been my experience. On the contrary, the subsequent action is salutary and protective. It prevents hemorrhage, after-pains, and puerperal fever. So confident am I of this, that it has been my almost uniform practice for many years to have my patient under the influence of an opiate, in all circumstances, at the birth of the child. If success be the measure of treatment, I can claim that, under this treatment, puerperal fever, convulsions, metritis and peritonitis, have been almost unknown in my experience.

It is my conviction that opiates in labor have a special influence in preventing inflammation, and protecting from puerperal fever. And why not, considering the extraordinary, often marvelous, benefit derived from the modern treatment of peritoneal inflammation by large doses of opium? But, as in peritonitis it is necessary to administer the drug with unsparing hand in order

to secure the good result, so in labor it must be given freely, though not in the quantity required in the former case. This is a matter of great importance. In both cases the practitioner should be guided by the perceptible effect, without regard to the quantity. Timidity will result in failure.

But what effect has the narcotism of the mother on the child? In some instances I have suspected that the infant had been narcotized from the mother's blood, inferring this from the difficulty in establishing respiration. But my observation leads me to the conclusion that such difficulty is as common where no opiate has been employed; so that I have long since ceased to fear any injury on this score.

To return to the subject of the forceps, let me classify operators, arranging them under three heads:

First—Incompetent and inexperienced, sometimes from indifference and neglected opportunities, more frequently from impossibilities in education. Some of these are foolhardy, rash and dangerous. Others are timid, and if they do not save life, they do not kill. They go for their forceps in difficult cases, but they are so long in getting them to work that, nine times in ten, the child is born first.

Second—Experts who work by the rule of force. Such a one seizes the instrument with resolution written on his features and in every movement. Knowing perfectly the relations of the parts, he determines from the start what shall be done and how to do it. The forceps must enter just so. They must obey his hand and take the exact position which he assigns to them. And when the head is seized, the question is simply one of mechanical force, or pulling. The result is speedy and often charming to look upon. *But*, sometimes he does serious harm. His motto is: "Fortiter in re."

Third—Experts deliberate, persuasive, and cautious. These go to work gently, allowing the instrument to take its own course, rather than forcing it, so that it enters almost like a living animal, and so quietly and smoothly that the patient is scarcely conscious of the operation, though not anesthetised. And then they perform traction in harmony with the natural efforts, qualifying the required force with tact and gentleness. Such operators often do the most when they appear to be doing the least. In their hands no harm will ever come of the forceps. Prominent with them is the maxim: "Suaviter in modo."

Discussion in the San Francisco Medical Society on the Paper of Dr. Gibbons.

Dr. Cachot agreed with the paper, especially in regard to the impropriety of interfering mechanically before the dilation of the os. He had used the forceps however very frequently in the advanced stage, and never in a single case to the injury of mother or child.

Dr. Sullivan was much pleased with the conservative views expressed by the essayist. He also considered the free use of opiates as safe and generally beneficial in labor. He would take occasion to mention the viburnum prunifolium as a valuable preventive of abortion, and also a remedy for the sickness of pregnancy. He gave a teaspoonful of the fluid extract three times a day, in a mixture with oil of mint to disguise the disagreeable taste.

Dr. Plummer condemned the too early introduction of the forceps, but thought them invaluable many times in the more advanced stage. He had been prevented from using them in one case by a consulting physician, and he was sure the life of the infant was sacrificed by the omission. In regard to opium in labor, he had once given a dose in the early stage for the purpose of arresting the progress while he should get some sleep, as the os was only beginning to dilate. He thought it impossible for labor to be completed within six or eight hours. But he was recalled in two hours and found that the child had been born long before his return.

Dr. W. Ayer agreed with the paper in regard to meddlesome midwifery, and also to the use of opiates in labor. He inquired of the author whether he preferred opium or morphia.

Dr. Gibbons said he had not much choice, but was governed by circumstances. The action of morphia was more evanescent. He was fond of combining the opiate with camphor. Camphor was of much value so combined, in modifying the action of opiates in puerperal women, and especially in promoting the relief of after pains.

Dr. Woodhull was much pleased with the protest against the too frequent use of the forceps. The instrument was valuable, but the tendency in many quarters was to apply it almost immediately. As to the viburnum, he had full proof of its

value in preventing abortion, but had not known it to be used for the sickness of pregnancy, as stated by Dr. Sullivan.

Dr. Grover had known many cases which confirmed the views expressed in the paper. He also believed in the efficacy of opiates in labor. Instead of retarding, they seemed to relax the uterus and facilitate progress.

Dr. Sullivan referred to an agent from which he had derived much benefit, in a case of enuresis accompanying diabetes—the rhus aromatica, a recently introduced remedy, of which he gave a teaspoonful of the fluid extract three times a day. Not only was the enuresis cured but the patient was nearly well of the diabetic affection.

Dr. Soule suggested that the enuresis in that case depended mainly on the quantity of urine secreted, and that the remedy had acted by diminishing the quantity. He inquired if Dr. Gibbons had ever employed quinia as an oxytocic, and if he had been in the practice of using chloroform. He was favorable to the use of opiates as described, unless in the advanced stage, when the woman was feeble. Here he found that twelve grains of quinine answered an excellent purpose.

Dr. Simpson favored the practice of giving opiates in labor, and particularly to relieve after pains. He usually gave his patients about thirty drops of laudanum at the birth of the child, if they had not taken any previously.

Dr. Gibbons, in answer to the inquiry of Dr. Soule, said he had not used quinine in labor, though he did not doubt its utility in the case stated. He had never been in the habit of giving chloroform in labor, and except in convulsions, or when convulsions were threatened, had given it only at the earnest desire of the patient, and then never to the extent of destroying consciousness entirely. He had been too well satisfied with the opiate practice to run any risk with chloroform, which was not introduced when he adopted the other practice. In regard to the viburnum, he could recommend that with great confidence as a preventive of abortion, and in various forms of uterine hemorrhage. It is a valuable remedy, though its place in therapeutics is not yet fully defined. Dr. Sullivan's use of it in the sickness of pregnancy was an important hint, of which he should take advantage, though he had generally succeeded with strychnia. As to enuresis, he had almost always succeeded in controlling it with belladonna, giving to a child ten drops of

the tincture at bedtime, and increasing it by one or two drops every night till some effect was manifest. In some instances he had added tincture of nux vomica with benefit.

The discussion was continued further, a number of gentlemen bearing testimony to the value of viburnum in various uterine affections, and in deranged menstruation. Ergot also was mentioned; several members giving an experience of entire failure with it in many instances, and success in others.